Sutter Health

SUTTER DAVIS HOSPITAL

2025 – 2027 Community Benefit Plan Responding to the 2025 Community Health Needs Assessment

Submitted to the Department of Health Care Access and Information
July 2026

Sutter Davis Hospital
2000 Sutter Place
Davis, CA 95616

License #30000124

www.sutterhealth.org

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Note: This Community Benefit Plan is based on the hospital's implementation strategy, which is written in accordance with Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

General Information

Date written plan was adopted by organization's governing body	October 17, 2025
Date written plan was required to be adopted	May 15, 2026
Authorized governing body that adopted the written plan	Sutter Valley Hospitals Board
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	Yes ☒ No ☐
Date facility's prior written plan was adopted by organization's governing body	July 21, 2022

Summary: 2025 Implementation Strategy

The Implementation Strategy (IS) describes how Sutter Davis Hospital (SDH), a Sutter Health system not-for-profit hospital, plans to address significant health needs identified in the 2025 Community Health Needs Assessment (CHNA) in calendar (tax) years 2025 through 2027.

The 2025 CHNA and the 2025 - 2027 IS were undertaken by the hospital to understand and address community health needs, in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The hospital reserves the right to amend this IS as circumstances warrant. As outlined in this document, SDH has identified the following significant health needs to be addressed in 2025-2027:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to quality primary care health services
4. System Navigation
5. Active Living and Healthy Eating
6. Injury and Disease Prevention and Management

SDH welcomes comments from the public on the 2025 CHNA and 2025 - 2027 IS. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at *SHCB@sutterhealth.org;*
- Through the mail using the hospital's address at 2000 Sutter Place, Davis, CA 95616; and
- In-person at the hospital's Information Desk.

Sutter Health's CHNA reports and IS plans are publicly available online at *http://sutterhealth.org/about-us/community-benefit/community-health-needs-assessment*. In addition, the IS will be filed with the Internal Revenue Service using Form 990, Schedule H.

Introduction/Background

About Sutter Health

Sutter Davis Hospital (SDH) is affiliated with Sutter Health, a not-for-profit healthcare system dedicated to providing comprehensive, high-quality care throughout California. Committed to closing care gaps and driving innovative healthcare solutions, Sutter is pursuing a bold new plan to reach more people and make excellent healthcare more connected and accessible. Currently serving 3.6 million patients, thanks to our dedicated team of approximately 64,000 employees (including nurses) and 15,000+ affiliated physicians and advanced practice clinicians, with a unified focus on expanding care to serve more patients.

2025 Activities to Address Community Health Needs

As part of Sutter Health's commitment to fulfill its not-for-profit mission, Sutter invests deeply in the communities it serves to help close health care gaps and improve individual and community wellness. Sutter's investments in community benefit programs and services increased to nearly $1.2 billion in 2025, including $101 million in traditional charity care, $830 million in unreimbursed costs of providing care to Medi-Cal patients, $101 million in training, education and development of future health care professionals, as well as investments in programs to address identified community health needs.

In 2025, SDH's investments in community health programs addressed pressing community needs in three main priority areas: access to care, including chronic disease prevention and management; mental health and substance use treatment; and workforce development.

Learn more about how Sutter Health reinvests into communities and works to advance healthy outcomes for all by visiting *sutterhealth.org/community-benefit*.

2025 Community Health Needs Assessment Approach

Community Health Insights (*www.communityhealthinsights.com*) conducted the 2025 CHNA on behalf of SDH. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model. [1] This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with community health experts, social service providers, and medical personnel. Furthermore, community residents or community service provider organizations participated in focus groups across the service area. Finally, community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization (see Appendix A for CHNA participants).

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as

[1] Robert Wood Johnson Foundation, and University of Wisconsin, 2024. County Health Rankings Model. Retrieved 18 July 2024 from *https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods*.

income, educational attainment, and employment. Further, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

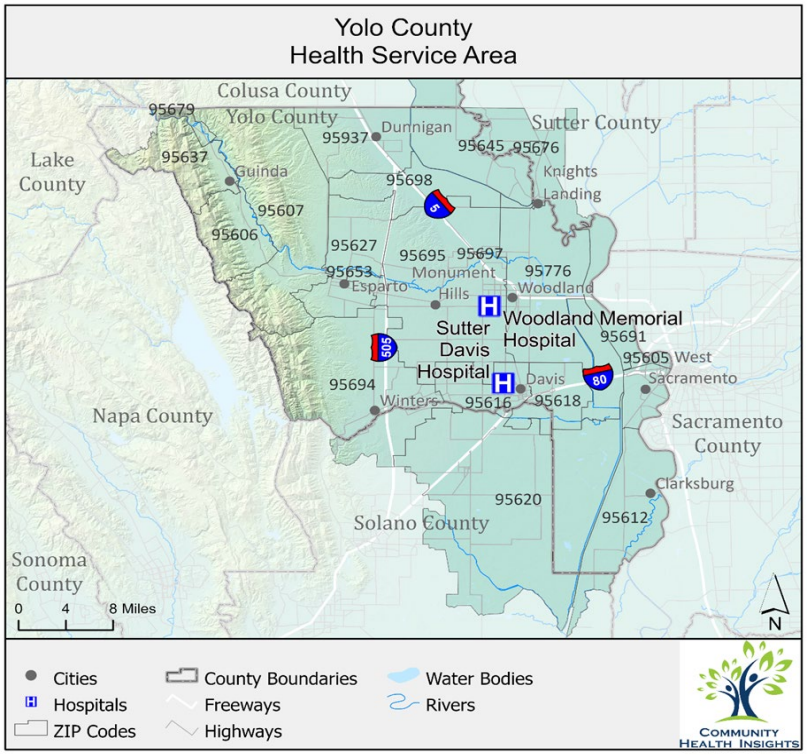
Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize SHNs. This began by identifying 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. These PHNs were selected as significant health needs (SHN). These SHN were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 12 PHNs identified in previous CHNAs.

Community Served

Yolo County was chosen as the geographical area for the CHNA because it is the primary service area of both hospitals participating in the joint assessment. Yolo County is located northwest of Sacramento along the Interstate 5 corridor and includes both urban and rural communities. The City of Woodland is the county seat of Yolo County (Figure 1).

Figure 1: Community served by SDH.



Selected population characteristics for SDH's service area are found in Table 1, below.

Table 1. Population Characteristics: Yolo County	
Total Population	*217,782*
Median Age (yrs.)	*32.3*
Median Income	*$88,818*
% Poverty	*16.3*
% Unemployed	*5.3*
% Uninsured	*4.6*
% Without High School Degree	*11.6*
% With High Housing Costs	*37.8*
% With Disability	*10.8*
Race/ethnicity	
% White	*43.01*
% Asian	*14.5*
% Hispanic or Latino	*33.2*
% Black or African American	*2.5*
% Multiracial	*5.4*
% Another race/ethnicity	*0.5*
% Native Hawaiian or Pacific Islander	*0.4*
% American Indian or Alaska Native	*0.4*

Source: 2022 American Community Survey 5-year estimates; U.S. Census Bureau.

Significant Health Needs Identified in the 2025 CHNA

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the service area. The following significant health needs were identified in the 2025 CHNA:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Increased Community Connections
5. System Navigation
6. Active Living and Healthy Eating
7. Injury and Disease Prevention and Management
8. Access to Functional Needs
9. Safe and Violence-Free Environment
10. Access to Specialty and Extended Care
11. Healthy Physical Environment

Sutter Health's Approach to Implementation Strategies

We are passionate about giving back to the communities that trust us with their health. As a not-for-profit health system, we improve health outcomes beyond the walls of our hospitals and care facilities through community benefit investments and collaborative partnerships. Community-based services, mobile clinics, transportation services, and prevention and wellness programs are among the ways Sutter Health seeks to put its mission into action. Our commitment to healthier lives begins with building stronger communities.

When creating our IS, we focus on innovative and effective strategies, collaborative partnerships and sustainable solutions to address the most pressing community health issues. Using the CHNA as our guide, we tailor our approach in each community to consider the unique needs of those living in the hospital service area. In addition to the CHNA, we also consider:

- Key stakeholder input from community leaders and service providers.
- Data analysis showing gaps in care for Medi-Cal and uninsured individuals.
- Where we can lend our health care expertise to provide valuable tools, perspective or services.
- Existing community capacity to determine where more resources are needed and avoid duplication of efforts.

We have streamlined our IS approach across the Sutter Health system to be more effective in meeting community needs and share best practices across regions. We have identified these three areas as our overarching community health goals:

- **Access to Care, including Chronic Disease Prevention and Management** – increase capacity and reduce barriers for vulnerable patients accessing primary and specialty care, and implement programs to prevent and manage chronic diseases.
- **Mental Health and Substance Use Treatment** – improve access to and quality of mental health and substance use disorder services in clinics, schools, community-based settings, and counties.
- **Workforce Development** – invest in the future generation of healthcare workers to improve the workforce pipeline and access to care.

Health Needs SDH Plans to Address

The health needs the hospital will specifically address in 2025-2027 are:

1. **Access to Basic Needs Such as Housing, Jobs, and Food** – Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[4] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.

2. **Access to Mental/Behavioral Health and Substance Use Services** – Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

3. **Access to Quality Primary Care Health Services** – Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

4. **System Navigation** – System navigation refers to an individual's ability to traverse fragmented social-services and healthcare systems to receive the necessary benefits and supports to improve health outcomes. Research has shown that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities.[7] Further, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

5. **Active Living and Healthy Eating** – Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often live in areas with fast food and other establishments where unhealthy food is sold. Under-resourced communities may experience food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals often lacking in sufficient nutrition for maintaining health.

SDH Implementation Strategies

To ensure we are meeting the needs outlined in our CHNA, each hospital's IS aligns with the prioritized health needs of the hospital's service area while also supporting our organization's strategic approach.

This IS describes how SDH plans to address significant health needs identified in the 2025 CHNA and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit,
- Anticipated impacts of these actions and a plan to evaluate impact, and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2025 CHNA.

Below is an outline of the priority health needs SDH plans to address by the end of 2027, as well as the goals and strategies we will implement to achieve the listed outcomes.

Priority Health Need	Goal	Strategies	Anticipated Outcomes	2026 Outcomes
Access to Basic Needs Such as Housing, Jobs, and Food	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Partner with programs that focus on chronic disease prevention, risk reduction, and management through improved access to screenings and treatment for chronic disease, health behavior and nutrition education, healthy and culturally appropriate foods, and physical activity opportunities for seniors, youth, and other vulnerable community members.	Community members experience access to chronic disease risk reduction education, screenings, and treatment, healthy foods, and physical activity opportunities.	In 2025, a total of 7,533 community members were served through investments in this strategy: • 1,089 received support for managing a chronic condition • 1,670 improved their nutrition knowledge • 250 increased their physical activity • 356,064 pounds of food were distributed.

	Cultivate a talent pipeline, enhance workforce readiness, and support the broader community.	Develop and improve sustainable career pathways in healthcare and other fields through investments in education, job training, technical and soft skill building, leadership development, employment services and supports, and financial coaching, among other programs and services.	Program participants will have access to education or job training and other services to support employment and address basic needs.	In 2025, 12 community members were served through an investment in this strategy, all of whom obtained employment through the program.
		Invest in capital projects that expand the capacity of workforce development initiatives in healthcare and other fields to provide education, job training, technical and soft skill building, leadership development, employment services and supports, and financial coaching, among other programs and services.	Educational institutions, collaboratives, and community organizations will make progress towards providing access to education/job training programs and sites for the community.	Planning for future investments to advance this strategy is underway.

Access to Mental/Behavioral Health and Substance Use Services	Cultivate community mental health by expanding access to inclusive, trauma-informed prevention, intervention, crisis and substance use disorder services through innovative, culturally responsive delivery systems.	Invest in a coordinated network of culturally responsive, trauma-informed, and community-based mental health and/or substance use prevention and intervention strategies—spanning prevention, crisis care and post-stabilization, housing and vocational support, integrated healthcare models, and workforce development—to optimize access, strengthen service capacity, and improve behavioral health outcomes for underserved, uninsured, and high-risk populations across all age groups.	Community members will have access to services addressing behavioral health, primary care and basic needs.	In 2025, a total of 2,274 community members were served through investments in this strategy: • 1,073 attended behavioral health appointments • Of those assessed, 882 experienced improved their mental health and/or substance use and 978 experienced reduced social isolation.
		Invest in trauma-informed mental health crisis response and navigation services that provide rapid access to stabilization, care coordination, and culturally competent support to reduce harm, avoid unnecessary hospitalization, and promote access to ongoing behavioral health care for all.	Community members will have access to behavioral health crisis services and other mental health support services.	In 2025, a capital investment was provided in support of a facility that will provide mental health crisis response and navigation services.

		Invest in upstream suicide prevention by identifying early risk indicators in patients and providing wraparound support to prevent crisis and promote sustained mental wellbeing.	Patients will have access to behavioral health services, including crisis and harm reduction services.	In 2025, 21 community members were served through an investment in this strategy; individuals received support after an inpatient or emergency department visit to maintain their overall well-being and linkage to community resources as needed.
		Invest in mental health interventions for youth to address emotional and psychological challenges early, optimize access for underserved populations, and support the development of coping skills, resilience, and long-term mental wellbeing.	Youth will have access to services addressing behavioral health, primary care and basic needs.	In 2025, a total of 192 community members were served through investments in this strategy: • 153 attended behavioral health appointments • Of those assessed, 60 experienced improved their mental health and/or substance use, and • 8,004 behavioral health appointments were provided.

Access to Quality Primary Care Health Services	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Partner with Mobile and Street Medicine programs that serve individuals experiencing homelessness and other vulnerable community members by traveling to them, providing healthcare, and facilitating patient connection to housing and other wraparound services.	Community members access healthcare and other services that support health and address basic needs.	In 2025, a total of 368 community members were served through investments in this strategy: • 387 accessed primary care services, • 271 enrolled in health insurance, and • 124 received support for managing a chronic condition.
System Navigation	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Invest in Community Health Worker/Promotores/ Navigator initiatives in which trusted community members connect individuals and families with community healthcare providers, clinics, care teams, and resources to address their health, social and/or economic needs.	Patients experience increased access to primary care and other community-based services that support health and address basic needs.	In 2025, a total of 1,783 community members were served through investments in this strategy. Services provided included: • 2,225 home visits, • 809 behavioral health appointments, and • 771 health education services.

Active Living and Healthy Eating	Improve access to healthcare and chronic disease prevention and management by investing in integrated, person-centered systems of care and partnerships across clinical, community, and educational settings.	Partner with programs that focus on chronic disease prevention, risk reduction, and management through improved access to screenings and treatment for chronic disease, health behavior and nutrition education, healthy and culturally appropriate foods, and physical activity opportunities for seniors, youth, and other vulnerable community members.	Community members experience access to chronic disease risk reduction education, screenings, and treatment, healthy foods, and physical activity opportunities.	In 2025, a total of 7,533 community members were served through investments in this strategy: • 2,590 experienced reduced social isolation, • 1,089 received support for managing a chronic condition, • 1,670 increased nutrition knowledge, and • 356,064 pounds of food were distributed.

Evaluation of Effectiveness

Sutter Health regularly monitors the impact and effectiveness of our community health strategies to ensure programs meet the needs of the communities we serve. We require all community partners who receive funding to report measurable outcomes, including but not limited to the outcomes identified in the table above, to demonstrate the impact of their programs. These reports help track program success, so that we may shift our strategies to more effectively meet the needs in the CHNA if needed.

Health Needs SDH Does Not Plan to Address

While no hospital can address all of the health needs present in its community, many health needs are interrelated. The following were not identified as the primary health needs to be addressed through this IS, though they remain important and are closely connected to our priorities: Increased Community Connections, Access to Functional Needs, Safe and Violence-Free Environment, Access to Specialty and Extended Care, Healthy Physical Environment, Injury and Disease Prevention and Management.

SDH is committed to serving the community by adhering to its mission, using our skills and capabilities, and remaining a strong community partner so that we can continue to give back to the areas we serve. To leverage our resources and expertise, we are prioritizing the needs we are positioned to most effectively address.

Appendix A: 2025 CHNA Participants

Key Informant Interviews

Table A1 contains a listing of community health experts, or key informants, that contributed input to the CHNA. The table describes the name of the represented organization, the number of participants and area of expertise, the populations served by the organization, and the date of the interview.

Table A1: Key informant list.

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Woodland Memorial Hospital	04/12/2024	3	Acute Care Hospital: Healthcare services	Countywide; Special focus on LatinX Spanish Speaking Community
Sutter Davis Hospital	04/09/2024	4	Acute Care Hospital: Healthcare services	Low-income residents of Yolo County; uninsured and underinsured
Yolo County Public Health Staff	04/22/2024	1	Public Health	Residents of Yolo County
Yolo County Public Health Leadership	06/04/2024	4	Public Health	Residents of Yolo County
Winters Health	04/15/2024	1	FQHC: Healthcare services	Rural, Hispanic, migrant communities
CommuniCare	05/09/2024	2	FQHC: Healthcare services	Low income, underserved
Yolo Food Bank	04/22/2024	1	Food insecurity	Seniors, low income families
Fourth and Hope	04/24/2024	1	Food, shelter, social services	Homeless
Woodland Joint Unified School District	07/26/2021	3	Education	School aged children; Hispanic
Yolo County Children's Alliance	05/16/2024	1	Child abuse prevention, policy and advocacy	Children and families of Yolo County
Rural Innovations in Social Economics (RISE)	04/29/2024	1	Food, clothing, referrals, after school programs	Low income, Hispanic, migrant community
Empower Yolo	05/17/2024	1	Crisis intervention, counseling, legal assistance, social services resources	Victims of domestic violence, sexual assault, sex trafficking
Yocha DeHe Wintun Nation	10/02/2024	1	Case management, health education, resources, referrals	Tribal citizens

Focus Groups

Table A2 contains a listing of community resident groups that contributed input to the CHNA. The table describes the hosting organization of the focus group, the date it occurred, the total number of participants, and population represented for focus group members.

Table A2: Focus group list.

Hosting Organization	Date	Number of Participants	Population Represented
Fourth and Hope	07/16/2024	9	Unhoused in Woodland
Yolo County Children's Alliance	08/12/2024	6	West Sacramento residents, working poor
Yolo Healthy Aging Alliance	09/03/2024	9	Seniors

Community Service Provider Survey

A web-based survey was administered to community service providers (CSPs) who delivered health and social services to community residents of the HSA. Eighteen respondents completed the survey. Survey respondents were asked if they would like the organizations they represented to be acknowledged in the report. The organizations represented by those respondents who requested acknowledgement are as follows. We thank all respondents for their participation in this process:

> The Sacramento Environmental Justice Coalition (Sac-EJC.org), Sierra Sacramento Valley Medical Society, Society for the Blind, Yolo Community Care Continuum, Mercy Coalition of West Sacramento, Meals on Wheels Yolo County, First 5 Yolo Children and Families Commission, RISE, Inc, CommuniCare+OLE, Short Term Emergency Aid Committee, YCCC/Haven House ICP, Yolo Food Bank; UC Davis Community Advisory Board

Appendix B: 2025 Community Benefit Financials

Sutter Health hospitals and many other healthcare systems around the country voluntarily subscribe to a common definition of community benefit developed by the Catholic Health Association. Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to community needs.

Community benefit programs include traditional charity care which covers healthcare services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Additional community benefit expenses are reported based on total cost incurred, offset by any restricted revenue received to determine net community benefit expense. Additional community benefit programs include the cost of other services provided to persons who cannot afford healthcare because of inadequate resources and are uninsured or underinsured, cash donations on behalf of the poor and underserved as well as contributions made to community agencies to fund charitable activities, training health professionals, the cost of performing medical research, and other services including health screenings and educating the community with various seminars and classes, and the costs associated with providing free clinics and community services. Sutter Health hospitals provide some or all of these community benefit activities.

Sutter Davis Hospital
Total Community Benefits & Unpaid Costs of Medicare
For period from 01/01/2025 through 12/31/2025

Financial Assistance and Means-Tested Government Programs	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$1,717,674		$1,717,674
Medi-Cal	$18,764,935		$18,764,935
Other Means-Tested Government (Indigent Care)	$5,393		$5,393
Sum Financial Assistance and Means-Tested Government Program	**$20,488,002**		**$20,488,002**
Other Benefits			
Community Health Improvement Services	$158,506	$0	$158,506
Community Benefit Operations	$0	$45,832	$45,832
Health Professions Education	$0	$1,792,813	$1,792,813
Subsidized Health Services	$0	$229,589	$229,589
Research	$0	$23,517	$23,517
Cash and in-kind Contributions for Community Benefits	$558,301	$22,650	$580,951
Other Community Benefits	$0	$0	$0
Total Other Benefits	**$716,807**	**$2,114,401**	**$2,831,208**

Community Benefits Spending			
Total Community Benefits	**$21,204,809**	**$2,114,401**	**$23,319,210**
Medicare	$24,142,816		$24,142,816
Total Community Benefits with Medicare	**$45,347,625**	**$2,114,401**	**$47,462,026**